Section B – Conditions of Funding: Acute Health

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Conditions of Funding: Acute Health

The standard conditions of funding, which are not program specific, are detailed in Schedule 1 of the Health Service Agreement 2000–01. The conditions below apply specifically to the Acute Health Program. This year, it incorporates sub-acute services.

1. Australian Health Care Agreement (AHCA) Framework

The Australian Health Care Agreement (AHCA) is the successor to the Medicare Agreement which expired on 30 June 1998. The AHCA is an agreement between the Commonwealth of Australia and the State of Victoria, to provide and jointly fund health care for eligible persons who choose to use State funded health services for the five years from 1 July 1998 to 30 June 2003. It outlines the principles that are to guide the delivery of public hospital services.

Public hospitals in Victoria must ensure that public hospital services are provided in accordance with the terms of the AHCA, and that eligible persons are able to access public hospital services as public patients.

An electronic version of the AHCA between Victoria and the Commonwealth is available on the Internet at http://www.dhs.vic.gov.au/ahs/index.html

Acute Health Circular 3/99 (as may be amended from time to time) provides further State Government advice on the AHCA.

1.1 Hospitals to work within the Framework of the AHCA

The AHCA commits the Commonwealth and Victoria to the following Principles:

1. Eligible persons must be given the choice to receive public hospital services free of charge as public patients;
2. Access to public hospital services by public patients is to be on the basis of clinical need and within a clinically appropriate period; and
3. Eligible persons should have equitable access to public hospital services, regardless of their geographical location.

The Commonwealth and Victoria agree that principles 2 and 3 are met if Victoria is using its best endeavours to achieve the outcomes sought in those principles to the greatest extent practicable.

Under principle 2, it is Victorian Government policy that both public and private patients should receive access to public hospital services on the basis of clinical need. The Victorian Government will allow preferential access for eligible veterans to public hospitals, but only so long as care of public patients is not impaired, consistent with principle 2. Greater detail is given in the Department of Human Services Victoria Hospital Circular 17/1998.

The AHCA provides that where an eligible person receives public hospital services as a public admitted patient, no charges will be raised for medical or hospital services. Under the AHCA, a nursing home type patient is excluded from being an eligible person in relation to public hospital services.

Based on the AHCA, State Government policy for charging non-admitted patients is set out in the State's Fees Manual, *Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals* (as may be amended from time to time) This information is available at the Department Internet website:

http://www.dhs.vic.gov.au/ahs/feesman/index.htm

1.2 Admission of Patients

None of the following factors is to be a determinant of an eligible person's priority for receiving hospital services:

(a) whether or not an eligible person has health insurance;

(b) an eligible person's financial status or place of residence; or

(c) whether or not an eligible person intends to elect or elects to be treated as a public or private patient.

1.2.1 The hospital will ensure that:

(a) an eligible person, at the time of admission, or as soon as practicable thereafter, elects or confirms whether he or she wishes to be treated as a public patient or a private patient and this election is recorded on the approved Patient Election form;

(b) in making the election referred to above, the eligible person is informed of the consequences of electing to be treated as a public patient and not as a private patient or vice versa;

(c) an eligible person's health insurance status or financial status or intention in respect of an election will not be a determinant in the priority for receiving hospital services; and

(d) any ineligible person is appropriately identified as such in the Victorian Admitted Episodes Dataset (VAED).

1.2.2 The hospital will only admit patients in accordance with the Minimum Criteria for Admission as specified in the PRS/2 Manual Version 10.0 dated July 2000 and shall provide documented justification for the admission of all Type C Professional Attention Procedures (exclusion list) patients or those admitted overnight for designated Band 1 procedures of the Health Insurance Basic Table as defined by subsection 4(1) of the National Health Act 1953 (Commonwealth) (See Hospital Circular 15/1998).

1.2.3 The hospital will make every effort to verify the place of residence of interstate patients.

1.2.4 The hospital will ensure that all patients admitted to hospital are asked whether they are of Aboriginal or Torres Strait Islander descent. The identification of Aboriginality is a mandatory data item to be reported by hospitals to the VAED. Aboriginal and Torres Straight Islander patients identified on the VAED will be funded at 10 percent higher than the nominated payment for WIES8.

1.3 Claims for Medicare Benefits

The hospital will ensure that aftercare services for public patients and outpatients and accident and emergency services do not attract claims for Medicare benefits or claims for benefits under Veterans' Affairs Legislation.

1.4 Pharmaceutical Benefits

Under the Australian Health Care Agreements the Commonwealth has offered the States and Territories an option for reform of the dispensing of pharmaceuticals. This will represent a major change in the provision of pharmaceuticals and their reimbursement for patients moving from the hospital to the community setting as well as some community patients. The new arrangements will come into effect when signed by the Commonwealth and State Ministers. This is expected to be early in 2000–2001. Details of the proposed arrangements will be circulated as soon as they are finalised. Until then, existing arrangements should continue.

1.5 Commonwealth-State Programs

Hospitals may receive specific purpose payments arising from Commonwealth-State Agreements. Funding received under such arrangements is subject to each program's specific conditions.

2. Basis For Determining Government Funding

2.1 Components of Funding

Public targets will comprise:

- *Target A* volumes, paid at the relevant rate;
- *Target B* volumes paid at the relevant rate;
- Sub-acute services paid at the relevant rate;
- Non-Admitted Patient Grants;
- Training and Development grants;
- Other specified grants, and
- Payments for Eligible Veterans'.

These grants and admitted patient and outpatient target volumes are shown in *Section A* and shown in the agency's Health Service Agreement.

Funding is provided to hospitals and Metropolitan Health Services on the basis that the current range of services provided are continued. Before hospitals or Metropolitan Health Services undertake a significant change in the range or scope of services, the planning implications of such a move must be discussed and agreed with the Department. In rural areas, the appropriate discussion should be held with the Regional Partnerships and Service Planning Manager. In the metropolitan area discussions should be held with the Acute Health Program and the Region. In all cases, the Director of Acute Health Division must provide the final approval.

Hospitals will also receive revenue from private patients. Government Grant payments to hospitals will consist of the hospital's entitlements as specified in the Policy and Funding Guidelines, the HSA and Conditions of Funding, net of the relevant patient revenue target (see clause 4).

2.2 Published Rates

The rates presented in this document and its attachments, including modelled budgets, do not include savings required from embedded taxes/specific network savings/network supplies and consumable savings. These rates do not reflect the "published rates" as referred to in contract arrangements with privately operated hospitals. the official published rate for services reflects adjustments for the above items.

The official published rate for non-metropolitan hospitals is:

a) For WIES8: $10.75 less than the rates per unit described in Section A.

b) For other items including sub-acute bed day rates; CRC funding rates; emergency services categorisation; radiation oncology units; training and development grant payments; dialysis program payment rates; VACS unit rate; DVA sub-acute rates: 0.5 of one percent less than the rate described in Section A.

The official published rate for metropolitan hospitals is:

a) For WIES8: $16.80 less than the rates per unit described in Section A.

b) For other items including sub-acute bed day rates; CRC funding rates; emergency services categorisation; radiation oncology units; training and development grant payments; dialysis program payment rates; VACS unit rate; DVA sub-acute rates: 0.77 of one percent less than the rate described in Section A.

2.3 Calculation of the Payment For Admitted patient Services

2.3.1 The term "weighted inlier equivalent separation" means the measure of activity calculated by multiplying the DRG weight by the number of Inlier Equivalent Separations in the DRG and summing over all DRGs. For 2000–01 this statistic will be abbreviated as WIES8. The method and calculation of WIES8 is shown in Section C.

Target A

2.3.2 For hospital patient throughput for public patients up to the level included in Target A, the case payment is :

Major Providers (Metropolitan Health Service & Barwon Health)	$2,240
Major Rural Group B (greater than 10,000 WIES)	$2,254
Rural Group B (less than 10,000 WIES) & Group C	$2,287
Rural Group D & Group E	$2,317

Target B

2.3.3 Hospitals have been given a Target B WIES8 which will be paid for at $1,750 for public patients.

Each metropolitan health service will be allocated 5 percent of its total WIES allocation as target B WIES. Metropolitan health services may advise that they do not wish to take up these target B WIES. This advice must be provided to the Acute Health Division in writing by 31 December 2000.

Rural hospitals will be allocated 3 percent of their total WIES allocation as target B WIES. Hospitals may similarly advise that they do not wish to take up these target B WIES, however, this advice must be provided to the Acute Health Division by 31 December 2000.

Target B WIES that are not taken up by hospitals will be reallocated to help meet higher priority elective and emergency demands.

Throughput Above Target

2.3.4 Throughput above target will in general not be paid. In ongoing recognition however of the difficulty of precise demand management, throughput in excess of target of up to 2 per cent will be paid at 50 per cent of Target B rate.

2.3.5 Same day "medical" targets are specified in each agency’s Health Service Agreement as a percentage of total actual throughput. Same day medical throughput in excess of the specified target will not be funded by the Department. The targets have been set at 6.5 per cent (excluding “exempt” hospitals).

Quarterly Targets

2.3.6 Quarterly targets will be determined by the agency. Actual throughput against target will be reviewed at the end of the second, third and fourth quarters. Funding adjustments may be made where actual performance varies significantly (more than 2 percent) from the nominated quarterly targets.

2.3.7 Nursing Home Type Patient Payment.

The hospital will receive $133 for each nursing home type bed day as reported in the VAED.

2.3.8 Rural/Isolated Payment.

This payment provides a contribution for isolated and rural hospitals for additional costs incurred in transferring some patients in non-metropolitan areas. This payment is supplementary to the higher WIES payment received by non-metropolitan hospitals and does not purport to represent a payment for total ambulance transfer costs in any individual patient case. The payment which applies to all WIES not just those with an ambulance component, is as follows:

For isolated hospitals the additional ambulance transfer payment is $36 for each weighted inlier equivalent separation up to the agreed contract volume.

For other rural hospitals the additional payment is $15 for each weighted inlier equivalent separation up to the agreed contract volume.

2.4 Department of Veteran Affairs (DVA) Patients

New funding arrangements for eligible DVA patients came into place from 1 July 1998. In accordance with these arrangements, separate capped public targets and uncapped veterans estimates were incorporated into hospital budgets during 1998–99 for WIES, sub-acute and nursing home type beddays. For 2000–01 WIES estimates have been adjusted, based on throughput reported on the VAED.

Hospitals received payment at a premium for these services to eligible veterans. Payment requires an exact match of hospital veteran data with DVA records. In addition, a premium was paid for VACS encounters and allied health occasions of service, and outpatient radiotherapy services as reported on AIMS.

In 2000–01 payments for VACS encounters and allied health occasions of service, and outpatient radiotherapy services to eligible veterans' require an exact match of hospital veteran data with DVA records. These data are to be provided monthly to the Department in an agreed electronic format.

For each hospital, the Department will specify an estimate of DVA patient throughput for the following services:

- WIES
- Sub-Acute Services
- VACS encounters
- Allied health occasions of service
- Outpatient radiotherapy weighted activity units
- Victorian Maintenance Dialysis Program
- Nursing Home Type

Notwithstanding the provisions of Clause 2.2 the Department will pay a premium rate applicable for all eligible DVA patients matched with DVA records (as reported in the VAED or where appropriate AIMS) including numbers in excess of the estimate. If hospitals do not achieve the DVA target, any funding which has been cash flowed will be recalled at the full DVA rate.

2.4.1 If the hospitalisation of an eligible veteran is likely to exceed a continuous period of 35 days, hospitals shall ensure that the veteran's status is reviewed and that either:

a) a certificate under Section 3B of the Health Insurance Act 1973 is given by a medical practitioner and forwarded to the Department of Human Services DVA Contract Manager forthwith, or

b) the Beneficiary is reclassified to a Nursing Home Type patient.

Where an admitted veteran's length of stay is greater than 35 days and no acute care certificate in accordance with (a) above has been forwarded to DVA by DHS, hospitals will only be reimbursed at the Nursing Home Type patient payment rate. For all the services included in this Section,

final payment for treatment of veterans will only be authorised after:

- The veteran's eligibility has been confirmed by the Department of Veterans' Affairs; and
- The veteran's unique number and veteran details reported to DHS exactly match those held by the Department of Veterans' Affairs for each eligible patient.

2.4.2 Hospitals that do not pay sufficient attention to these requirements and make assumptions about eligibility for patients who are rejected or amended by DVA will need to reclassify these patients to reflect any changes in care type and the preferences indicated by the patient on the form of election for admission. **This will be strictly enforced in 2000–01 and hospital funding adjusted where the forms are not provided. The Department will not accept any risk for this "assumed" revenue.**

2.4.3 Principles and clauses in the Australian Health Care Agreement mean public hospitals may provide preferential access for veterans, provided care of public patients is not impaired. This will ensure the ability of public providers to compete on an equitable basis with the private sector in terms of access. The premium price paid for treating veterans will ensure the ability of public providers to compete on at least an equitable basis with the private sector in terms of quality.

2.4.4 Experience has shown that those hospitals which actively develop service quality and marketing plans to attract and retain veterans are more likely to in fact retain such patients. Hospitals are therefore strongly advised to develop such plans.

Information on Veteran and War Widow(er)s Services

2.4.5 Eligible Veterans and War Widow(er)s have access to a wide range of benefits and services through the Department of Veterans' Affairs. These include (but are not limited to) hospital, medical and allied health services, respite and convalescent care, rehabilitation aids and appliances, assistance with transport and accommodation allowance. Further details can be obtained under DVA Facts or Health from the Internet at http://www.dva.gov.au/health/vets_info.htm

2.5 Non-Admitted Patients Grant

2.5.1 The Victorian Ambulatory Classification System (VACS) operates in selected hospitals. For details of the VACS system and funding allocations including emergency department allocations for 2000–01 refer to *Section A*.

2.5.2 For non-VACS funded hospitals, the non-admitted patients grant is for the provision of services reported on the AIMS S2/111.

2.5.3 Hospitals are required to provide reports on occasions of service as part of State responsibilities under the existing Australian Health Care Agreement. The AIMS S2 is used for reporting this data.

2.5.4 VACS funded hospitals are required to report clinic level data via the AIMS S9/111. In the case of a new clinic commencing during the year, or

changes to existing clinics, assignment to a VACS category will be made by the hospital. The hospital is required to advise the Department of any changes occurring during the year by submitting details on the Notification of Clinic Changes form by 28 February 2001.

2.5.5 If there is a significant reduction in services to non-admitted patients in non-VACS funded hospitals the grant may be reduced during the course of the financial year. (A significant change for the purpose of this clause is defined as one which involves a reduction in the service levels of more than ten percent.)

2.5.6 Hospitals are responsible for providing such ambulance transport as is necessary, on clinical grounds, to ensure access for outpatients without charge to these patients.

2.5.7 The Victorian Ambulatory Classification System patient payments are calculated as follows:

- VACs rate per weighted encounter $114
- Allied health per occasion of service $42

2.5.8 For VACS funded hospitals where hospitals failed to reach target levels set for 1999-2000, adjustments have been made for the 2000–2001 targets.

2.6 Training and Development Grants

2.6.1 The Training and Development Grant is paid to hospitals in recognition of the additional costs to those hospitals engaged in teaching, training and research activities. This Grant was developed in recognition of the costs inherent in the training and research activities of teaching hospitals. These activities are for the most part, inextricably linked to clinical hospital services. This funding program also represents a compensatory payment to accommodate case complexity, including leading edge treatments.

The basic structure of the Grant will not be altered in 2000–01. This Grant will, however, be the subject of review as outlined in the Ministerial Review of Health Care Networks.

The Training and Development Grant is allocated to fund the specific programs and positions specified in the Health Service Agreement supplementary tables. The grant will be paid to the employer of the funded position. Where training positions include a period of rotating placements, participating agencies are required to ensure that the host agency receive a proportion of the grant equal to the length of the rotation.

2.6.2 Where positions remain unfilled by staff with credentials approved by the Department or programs offered by the hospital are not operated at budget levels, the Training and Development Grant will be adjusted to reflect actual performance.

2.6.3 Funding for all nursing programs is based on the academic year and is dependant on adequate financial acquittals being provided to the Department of Human Services regarding expenditure of the Grant.

2.6.4 Graduate Nurse Programs must meet the following criteria:

(a) hospitals must participate in the Nursing Computer Match Service in order to attract funding for Graduate Nurse positions;

(b) no fees are to be charged to nurses applying for, undertaking, or exiting from Graduate Nurse positions; and

(c) the positions offered must be full time. Under exceptional circumstances exceptions may be made following consultation with the Department of Human Services.

In addition, the programs should conform to the *Graduate Nurse Program Guidelines* Department of Human Services (September 1997).

2.6.5 For the Graduate Nurse, Student Midwife and Postgraduate Programs, approval must be sought from the Department of Human Services for any increase in numbers over and above projected numbers submitted at the start of the academic year.

2.6.6 Student Midwives

(a) Funding is at the level of $3000 per student midwife undertaking clinical experience for a minimum total of 50 days during the academic year.

(b) Adjustment may be made to the amount of funding to those hospitals which accommodate a large number of students undertaking clinical placement for periods of less than 50 days. Prorata funding for these students may be provided after discussion with the Department.

2.6.7 Rural Supplement.

(a) A supplement of $250 per nurse will be allocated to rural hospitals that offer specialist nursing courses in collaboration with a university to support costs incurred by nurses who must undertake a clinical placement a significant distance from the hospital where they are employed.

(b) The ‘significant distance’ criteria are to be agreed upon by the Regional and Central Office.

2.6.8 The research and development component of the Training and Development Grant is designed to fund research infrastructure for the hospital (including support for institutional ethics committees) together with support for academic units based at the hospital, including units funded by universities and independent research institutes. Hospitals in receipt of this grant will need to demonstrate that at least the amounts allocated have been expended for these purposes.

2.6.9 The Training and Development Grant also includes a component (10 percent) designed to fund the cost associated with clinical placements of undergraduate students including medical, nursing and allied health students. The allied health undergraduate component is allocated on the basis of clinical placement days.

2.7 Payments for Specified Purposes

2.7.1 Additional payments will be provided to the hospital for specific agreed services.

2.7.2 Where the grant is based on a particular level of service, and there is a significant reduction in such services, the grant may be reduced during the course of the financial year. (A significant change for the purpose of this clause is defined as one which involves a reduction in the service levels of more than ten percent.). Where an increase in the particular level of service is agreed with the Acute Health Division, an increase in funding may also be agreed.

2.8 Victorian Maintenance Dialysis Program

Victorian Maintenance Dialysis services will continue to be funded under the existing model which is constituted of a variable payment and a fixed capitation grant.

2.8.1 Hospitals participating in the Victorian Maintenance Dialysis Program will receive funding in two components: a program grant; and (for admitted patients) a case payment.

2.8.2 The program grant will be received by parent hospitals. Parent hospitals are required to negotiate with satellite centres arrangements for the provision of satellite dialysis services to be funded by the program grant. Parent hospitals have a responsibility to ensure that adequate compensation is made to satellite hospitals for services provided.

2.8.3 The payment rates for 2000-01, adjusted for award increases, CPI and productivity savings are as follows:

Treatment Modality	2000-01 Variable Payment Per Patient Per Annum	1999-2000 Revised Block Grant	2000–01 Block Grant
In-Centre	$17,182	$25,018	$21,877
Satellite	$17,182	$19,909	$21,877
Home Haemodialysis		$28,366	$28,857
Continuous Ambulatory Peritoneal Dialysis		$35,693	$36,311
Intermittent Peritoneal Dialysis		$25,685	$26,130

2.8.4 All reporting will continue to occur through the Victorian Admitted Episode Database (VAED) and the Agency Information Management System (AIMS).

2.8.5 Where hospitals need to treat the number of patients above the agreed number, this may be done by converting inpatient public WIES with the prior agreement of the Acute Health Division.

2.8.6 For dialysis services provided within the hospital, variable payments will also result from the VAED coding of the admitted patients as set out in Section C.

2.9 Sub - Acute Services

Sub-acute services are now managed and funded by the Acute Health Division. This includes rehabilitation, geriatric evaluation and management, geriatric respite inpatient services, and non-admitted specialist clinics including community rehabilitation. Budgets and targets for services transferred from the Aged, Community and Mental Health Division modelled in this document are notional and will be finalised by 31 August 2000.

Calculation of the Payment for Inpatient/admitted Sub-Acute services

2.9.1 Designated rehabilitation services with 20 beds or more are funded through VicRehab see below.

Recognised geriatric evaluation and management services, geriatric respite services and designated rehabilitation services up to 19 beds are funded with capped bedday targets for non-DVA patients.

DVA patients are funded separately and DVA estimates are not capped. Shortfalls in DVA throughput cannot be substituted by public patient throughput.

Bedday activity and throughput are calculated from data reported to both the VAED and the Agency Information Management System (AIMS: 305 S4). Where the actual number of bed days provided is less than the target, payments will be adjusted to reflect the actual service provision. No payment will be made for services in excess of the target.

Funding for sub-acute services for 2000-01 are based on the following bedday rates:

- Rehabilitation - Level 1: $406 per bedday
- Rehabilitation - Level 2 and 3: $338 per bedday
- Geriatric Evaluation & Management: $338 per bedday
- Geriatric Respite / NHT: $133 per bedday

Additional post-acute inpatient services have been also allocated as a component of the Winter Emergency Demand Strategy and funded at the rate of $320 per day. Post-Acute services are identified in VAED as *Care Type 9 - Geriatric Evaluation & Management*, with *Admission Type Z - Post-Acute Care*

VicRehab Model for Rehabilitation

2.9.2 The VicRehab classification system and funding model introduced in 1999-2000 will apply for all designated units with 20 beds or more. These units comprise:

- Austin and Repatriation Medical Centre
- Ballarat Health Services-Queen Elizabeth Centre

- Barwon Health-Grace McKellar
- Bendigo Health Care Group-Anne Caudle Campus
- Bundoora Extended Care Centre
- Caulfield General Medical Centre
- Goulburn Valley Health
- Hampton Rehabilitation Hospital
- Kingston Centre
- Latrobe Regional Hospital
- Mount Eliza Aged Care & R.S
- North West Hospital
- Peter James Centre
- Royal Talbot Rehabilitation Centre
- St George's Health Service
- St Vincent's Hospital
- Sunshine Hospital.

Funding for these units will be based on weighted units for Level 2 patients using the CRAFT classification. It will also include specified grants for Level 1 and Level 2 categories: amputees, spinal, head injury and burns cases. DVA patients (refer Chapter 2) will continue to be paid at a bed day rate.

Level 1 rehabilitation is for use by designated specialty programs providing rehabilitation following spinal cord injury, head injury or amputation and only where the rehabilitation episode directly follows the acute care episode in which the injury was the principal diagnosis.

Subsequent episodes of care following the initial rehabilitation episode are not classified as Level 1.

A budget/activity cap will be allocated to VicRehab agencies. Rehabilitation weighted units and beddays will be calculated from data reported to the VAED.

Funding levels continue to be guaranteed to the current Metropolitan Health Service regional levels for VicRehab funded units for 2000-2001. Where service movement has occurred during 1999-2000 from a previously non-VicRehab funded unit to a funding guaranteed unit, funding levels will be reviewed. As previously advised compensation grants will continue to apply for 2000-2001.

2.9.3 Flexible Funding Arrangements

- Home Based Care

The conditions of funding are given in *Section A—Chapter 12.2.4.*

- Unassigned Bed Funding - Geriatric Evaluation and Management

The conditions of funding are given in *Section A—Chapter 12.2.4.*

- Continuum of Care – Geriatric Evaluation and Management

The conditions of funding are given in *Section A—Chapter 12.2.4.*

2.9.4 Calculation of Payments for Non-Admitted Sub-Acute services

The conditions of funding are given in *Section A—Chapter 12.3.1.*

2.9.5 Reporting requirements for Sub Acute Services

Inpatient/Admitted Patients

All sub-acute services will report patient activity and throughput to both the VAED and AIMS data collections. For PRS/2 all admitted sub-acute patient records must include transmission of the completed S2 Sub-Acute Record on separation.

AIMS data collection is applicable to all funded sub-acute services, including those previously funded by the Acute program. All sub-acute admitted services are to be reported on the following two returns:

111 S1 Admitted Patients.

305 S4 Admitted Patients by Sub-Acute Stream of Care.

Standard definitions and reporting requirements are specified in current versions of the PRS/2 Manual, the Agency Information Management System Public Hospital User Manual and other amending documentation prepared by the Department.

Reporting arrangements for the Winter Emergency Demand Strategy are outlined in HDSS Bulletin 11 - 16 May 2000. Timeframes and further details are provided in Section 6.

Non-Admitted Patients

Community Rehabilitation Clinics will report patient activity and throughput to both the Community Rehabilitation Clinics Minimum Data Set and Performance Indicators (Oct 1998) and AIMS data collections on 305 S2: Non-Admitted Patients.

Specialist Clinics, including continence, falls and mobility and pain management clinics funded through the sub-acute program, will report patient activity and throughput to both the Specialist Clinics Minimum Data Set and Performance Indicators (July 1999) and AIMS data collections on 305 S2: Non-Admitted Patients.

2.10 Radiation Oncology.

A payment per weighted activity unit will be provided at the rate of $108 per weighted activity unit. Payments for weighted activity units and for specified grants will be based on monthly statistical returns from the hospital (AIMS 111/S8).

Growth of up to 4 percent on public patients only, will be funded at the full variable rate.

2.11 Hospital To Home—Effective Discharge Strategy

The Effective Discharge Strategy applies to acute hospitals, sub-acute services and Multi-Purpose Services (MPS).

2.11.1 Hospitals and sub-acute services are required to:

- Have a discharge improvement plan with targets where appropriate.
- Involve representatives from community provider organisations in the annual review and evaluation of the discharge plan.
- Consult with clients and their carers regarding their discharge needs and arrangements required, and ensure a timely transfer of information pertaining to a patient's discharge to patients and their family/carers, GPs, other community based providers, and other receiving hospitals/services.
- Provide to all clients on discharge, a single hospital point of contact for follow-up phone calls for professional information, advice and support following discharge.
- Document in the patient record the discharge plan and discharge arrangements made.
- Participate in other activities of the Effective Discharge Strategy, such as patient record audits, field testing of performance indicators, making available resources and tools developed to the Department and other hospitals.

2.11.2 Hospitals and sub-acute services should report to their new Metropolitan Health Service and rural Board of Management.

- Discharge Improvement Plans.
- Details of the review and evaluation of the discharge improvement plans.

2.11.3 By June 2001 it is expected that all patients discharged from a public hospital in Victoria will be provided with information containing the name and number of a contact person from whom they can seek post-discharge advice relevant to their hospitalisation.

2.12 Hospital to Home—Post Acute Care

Eligibility

2.12.1 To receive additional post acute care services through the PAC program, clients must:

- be a patient of a public hospital. This includes patients who have been admitted to the Emergency Department;
- be assessed as requiring additional services to assist with recuperation or transition to continuing care following an acute WIES-funded episode (this does not include patients discharged from a sub-acute or acute psychiatric episode of care but does include patients discharged from an acute WIES-funded "same day" episode of care);
- consent to receive additional post acute care services under the PAC

program; and
- agree to the forwarding of individual de-identified client level data to the Department for the purposes of program monitoring and evaluation.

Provider Arrangements

2.12.2 If patients are assessed by the hospital as requiring additional post acute care services and are eligible for PAC, the PAC Service should:
- develop, coordinate and implement a post discharge care plan;
- purchase an individually tailored package of health and community care services in accordance with the post discharge care plan developed above;
- review client needs and adjust services accordingly;
- facilitate transition to continuing care where required by referring PAC clients to appropriate health and community care agencies, prior to their exit from the PAC program.

Hospitals are responsible for implementing and providing effective discharge for their patients. As such, PAC Services are encouraged not to take on those tasks within the discharge process which are the responsibility of the hospital, including risk screening and assessment processes.

For the purposes of the PAC program, the following guidelines have been established to assist projects in purchasing services for clients:
- For clients receiving services prior to admission to hospital, these services should be maintained at existing levels during and following the post acute care episode, at no charge to the PAC program. Where additional services are required for post acute care, these may be charged to the PAC program.
- For clients who have continuing care needs beyond the post acute care episode, PAC services should arrange for these needs to be met through referral to suitable health and community care providers.

Department of Veterans Affairs Clients

2.12.3 As in 1999–2000, additional funds will be available for PAC Services for service provision to Department of Veterans Affairs (DVA) clients. Details of the arrangements will be provided.

Reporting and Accountability Requirements

2.12.4 PAC Services are required to comply with the following reporting arrangements:
- participating hospitals to record on the Victorian Admitted Episodes Dataset (VAED), all patients discharged from hospital and admitted to the PAC program, by the use of formal separation Type H accompanied by Separation Referral code P in accordance with the PRS/2 Manual, 10th Edition, 1 July 2000;
- no later than ten working days following the end of each quarter, provide electronic quarterly and year-to-date reports, containing information at least equivalent to that provided by the PAC Service

Accountability Reports and Financial Accountability Reports generated by the Care Manager 2000 software. The information provided electronically following the end of each quarter, as above, is to include data which is in a format compatible with the Department's PAC Reporting Module, such as that generated by the Care Manager 2000 software.

- no later that ten working days following the end of the financial year, or as required by the Department for monitoring and evaluation purposes, provide de-identified client data, as provided by the Encrypted Backup function of the Care Manager 2000 software;
- by 31 July, 2001 submit a certified statement of income and expenditure on an accrual basis for the 2000–01 financial year in a format to be specified by the Department.
- advise the Department of intention to change the auspice, management structure or hospitals to be serviced by the PAC Service; and
- provide other information as required by the Department.

2.13 Hospital In The Home

Patient Eligibility

2.13.1 The Hospital In The Home (HITH) Program is available to acute public patients, DVA, TAC, and Work Cover clients.

Patients in residential care (nursing homes, hostels, supported accommodation and other residential care facilities) are eligible for HITH.

For patients to be eligible to be treated under HITH, they must:

- be assessed as clinically suitable for home based acute care;
- have appropriate support in the home, ie. a carer;
- have a suitable home environment;.
- be fully informed about HITH, their rights and obligations and those of the providing hospital;
- choose to be treated in HITH and provide written consent to be treated in HITH;
- be registered as admitted patients who are transferred to HITH care.

2.13.2 Hospitals participating in the Program must ensure that they have appropriate patient selection, admission, treatment and discharge protocols.

2.13.3 Findings of the 1997-98 Service Audit conducted for the Department relating to individual hospitals and the final report should be implemented by participating hospitals.

2.13.4 Participating hospitals are encouraged incorporate the HITH standards developed by Victorian Centre for Ambulatory Care Innovation (VCACI) in consultation with the field.

2.13.5 Patients are eligible to receive the full range of services they would have normally received in hospital. Participating providers may either

provide HITH services directly or purchase services from health and community care providers.

Quality improvement initiatives

2.13.6 The purpose of quality improvement funding is to provide specified, project based and time limited funding for initiatives which improve quality, accessibility, promote growth, improve efficiency and effectiveness. These projects could focus on: new research and development; development of new/improved service models/practices; medical leadership; nursing education; expanding the application of HITH; addressing specific rural issues; and improvements in the interface with other service sectors.

Proposals will be assessed against the following broad criteria: the importance or relevance to the delivery of HITH services; the generalisability or transferability of results; the involvement of other partners/hospitals; and the extent to which results can be cost effectively implemented in hospitals.

Submissions for quality improvement initiatives must be submitted using a proforma that will be sent to hospitals in early July by 30 September 2000.

Reporting and Accountability

2.13.7 All participating hospitals are required to record patients treated under HITH on the VAED as Accommodation Type 4 in accordance with the PRS2 Version 10, July 2000.

Additional information may be sought from hospitals in the form of progress reports for the purposes of continuing policy and program development.

Hospitals receiving a quality improvement grant will be expected to provide a brief interim report half way through their project to demonstrate satisfactory progress and at the end of the project , to provide a written report on the project. HITH providers will be expected to provide a verbal report on their project at appropriate forums.

Monitoring, Evaluation and Review

2.13.8 Hospital activity will be monitored via the VAED on a half yearly basis. The Department will distribute HITH activity reports to participating Hospitals, and the HITH Advisory Committee.

2.14 Home Enteral Nutrition.

Client Eligibility.

2.14.1 For clients to be eligible to receive HEN services through the Program, they must:

- be managed by a health care provider participating in the program;
- live in the community and not in a Commonwealth funded residential care facility;

- make a standard copayment if they are not health care card or equivalent concession card holders.

HEN Funding

2.14.2 The funding is to be used to purchase the formula, equipment and consumables required by eligible clients for their HEN treatment. This includes the following:

- enteral formula
- non-consumable hardware (eg. pumps, drip stands)
- enteral tubing replacements (eg. replacement parts, spare tubes)
- consumables (eg. syringes, pump delivery sets, gravity delivery sets, formula containers)
- cost of home delivery.

Provider Arrangements

2.14.3 Health care providers receiving this funding are required to:

- undertake clinical reviews of clients
- provide written information to clients about HEN services, hospital arrangements and client rights and responsibilities.
- implement and adhere to the best practice guidelines as described by the AuSPEN Clinical Practice Guidelines for Home Enteral Nutrition.

2.14.4 Hospitals are encouraged to continue to make use of the Hospital HEN Register for local patient and program management.

Budget And Funding Arrangements

2.14.5 As in 1999-2000, Metropolitan Health Services, other participating metropolitan hospitals and Major Rural Regional Hospitals will be responsible for the management and accountability of funds allocated by the Department. However, all hospitals with eligible clients will be able to participate in the Program and receive funds through their Metropolitan Health Service or Major Rural Regional Hospital.

- Geelong Hospital — Barwon South Western Region
- Ballarat Health Services — Grampians Region
- Bendigo Health Care Group — Loddon Mallee Region
- Latrobe Regional Hospital — Gippsland Region
- Goulburn Valley Base Hospital — Hume Region

2.15 Continuous Positive Airways Pressure (CPAP)

Client Eligibility

2.15.1 Clients eligible for CPAP services through this program must:

- be managed by a hospital participating in the Program and assessed by an accredited sleep laboratory;
- have 20 apnoeas/hypopnoeas per hour and/or 15 apnoeas/ hypopnoeas per hour with underlying cardiovascular, neurological or pulmonary disease;
- be health care card or equivalent concessional card holders or otherwise demonstrate financial disadvantage;
- comply with CPAP usage requirements.

Provider Arrangements

2.15.2 Hospitals participating in the CPAP Program are responsible for:
- coordinating client assessment through sleep disorder centres;
- prescribing CPAP services and authorising a supplier to provide CPAP services;
- ensuring follow up and compliance through supplier(s) of CPAP services;
- undertaking clinical reviews at one and three months and then annually including sleep studies where necessary.

Budget And Funding Arrangements

2.15.3 Hospitals may use up to 15 per cent of the total CPAP grant for administration purposes.

2.16 Victorian Artificial Limb Program (VALP)

Client Eligibility

2.16.1 VALP provides artificial limb services to consumers who:
- are public inpatients and non-admitted patients;
- are managed by a hospitals participating in VALP;
- are not covered by compensable insurance arrangements such as Transport Accident Commission or WorkCover;
- are not Department of Veterans Affairs patients.

The provision of second limbs for adult consumers, including limbs for occupational or recreational purposes are not available through VALP. The Program will provide second limbs for children if they are assessed to be clinically required.

Provider Arrangements

2.16.2 Providers are expected to provide services within a quality framework which:
- are accessible to consumers;
- reflects current best practice in clinical, manufacturing, follow-up and other means of service delivery.

Budget And Funding Arrangements

2.16.3 In 2000-01, funding for artificial limb services will be provided as a block grant based on expenditure in 1999–2000. Operating budgets have been rolled into the expenditure budgets. Budgets are capped and providers must ensure that services provided are cost effective and operate within their allocated budgets. Providers are expected to prescribe on the basis of assessed clinical need within the total budget available.

2.17 Hospital Accreditation.

Accreditation Outcomes Program

2.17.1 Under this program, all hospitals and networks are required to provide either an Accreditation Outcomes Report (AOR) or an Accreditation

Update (AU) to the Department, depending on where an individual hospital/network is placed in their accreditation cycle.

2.17.2 For hospitals that will be undergoing an organisation wide external survey or a periodic external review (usually at the mid-point of an accreditation cycle) in 2000–01, an AOR should be provided. This will specify:

- the level of accreditation achieved and expiry date;
- recommendations made by surveyors for improvement;
- high priority recommendations for action;
- outstanding achievement ratings, general commendations or equivalent, and;
- intended responses by the hospital/network to address recommendations made, including time frames.

All AORs should be forwarded directly to the Quality and Care Continuity Branch of Acute Health within 60 days of receiving an accreditation survey or review report. A proforma AOR has been developed in consultation with all hospitals and networks. All AORs should be submitted on this template in either hard-copy or electronic format. The AOR proforma was distributed to all hospitals and networks in January 2000; further copies may be obtained from the Quality & Care Continuity Branch.

2.17.3 For hospitals that are not scheduled to undergo any external accreditation survey or review in 2000–01, an AU should be provided.

This should specify:

- the action taken in response to any high priority recommendations or recommendations that were made to the hospital in their most recent accreditation survey report, and that were communicated in an AOR to the Department in 1999-2000.
- the scheduled date for the hospital/network's next external accreditation survey or periodic review.

All AUs should also be forwarded directly to the Quality and Care Continuity Branch of Acute Health. The AU can take the form of an updated version of the hospital/network's quality action plan that was submitted with an AOR in 1999-2000.

Accreditation Bonuses

2.17.4 In 2000–01, accreditation bonuses will be linked to the provision of an AOR or AU to the Department. The purpose of these bonuses is to support the development and further improvement of data collection systems for the monitoring and reporting of performance indicators and for quality improvement projects identified from accreditation survey outcomes.

Upon receipt of an AOR or AU in 2000–01, all category A1, A2 and B hospitals will be eligible for a bonus of $30,000; all category C, D and E hospitals and acute funded Multi Purpose Services will be eligible for $15,000.

Public Reporting of Accreditation Outcomes.

2.17.5 The Department will continue to publish a list of acute funded accredited public hospitals, including the period of accreditation awarded (expiry date) and the accreditation program, in the *Hospital Services Report*. In 2000–01, this information will be published on a six monthly basis for the periods ending 31 December 2000 and 30 June 2001 respectively.

2.18 Specific Purpose Grants for Services to Persons from Non-English Speaking Backgrounds (NESB)

2.18.1 Metropolitan Health Services and hospitals will be notified of NESB grants for 2000–01.

2.18.2 The broad intent of these grants is to encourage hospitals to improve service delivery to admitted patients of non-English speaking background. Hospitals receiving grants are required to be able to spend the amounts allocated on strategies which are consistent with those outlined in the publication *Working with Patients from non-English speaking backgrounds: Guidelines for Health Agencies*.

2.19 Hospital Access Program.

The Hospital Access Program payments will be determined in accordance with the provisions of Section A—Appendix 3.

2.20 Maternity Services Program

Provider Arrangements

2.20.1 Hospitals are expected to provide:

- provision of at least one postnatal domiciliary visit to every woman giving birth and further visits for women with special needs;
- a wider range in the models of maternity care offered to women;
- increased continuity of care, with respect to hospital care and integration with the community provision of antenatal and postnatal care and support;
- improved responsiveness to women with special needs;
- improved arrangements for monitoring, review and improvement in the quality of care, and
- greater opportunities for consumers to make informed choices, participate in decision making and provide feedback for service improvement.

2.20.2 Hospitals are required to ensure adequate postnatal care for women and their families according to clinical and psycho-social needs. This is defined as offering as a minimum:

- at least one postnatal home visit for all women following discharge from hospital and more depending on postnatal length of stay in hospital.
- at least two postnatal home visits or more if required for women with special needs, such as women from diverse cultural backgrounds, newly arrived migrants, single young mothers, women with disabilities and first time mothers

- at least two or more postnatal home visits for women after a caesarean section, or with complications arising from the birth or immediate postnatal period.

Reporting Requirements

2.20.3 Hospitals are required to participate in the mid-term review which will examine the extent to which the objectives of the program are being met. Hospitals will be expected to participate and collaborate and contribute to research and evaluation conducted as part of the maternity services program.

2.20.4 Hospitals are required to provide patient level data monthly, on postnatal domiciliary care through **both** the Victorian Admitted Episode Data System and the Agency Information Management System : Domiciliary Postnatal Services: Form 111/D1.

2.21 Co-ordinated Care Trials

Phase II of the coordinated care trials are expected to commence on 1 January 2001. Some Metropolitan Health services and rural hospitals will be participating in these trials. Participation in the trial will involve the reallocation of the value of the designated WIES from the Health Service to the Coordinated Care Trial.

Coordinated Care trials are jointly funded by the Commonwealth and the State to coordinate the care of a selected group of the population who are either chronically ill or who have ongoing complex medical needs. The aim of the trials is to test the hypothesis that coordination of care of people with multiple service needs, where care is accessed through individual care plans, and funds pooled from existing Commonwealth, State and joint programs, will result in improved individual client health and well-being within existing resources.

The trials involve the pooling of a negotiated quantum of public hospital WIES with MBS and PBS payments, and funds from other agreed health programs to allow trials to purchase the range of health services required to support the trial participants. Services to be purchased will include acute admissions.

Relevant hospitals will be expected to negotiate the level of pooled WIES with the Trial. If this cannot be successfully completed within a reasonable time the Department will arbitrate.

2.22 Redirection of Funds.

Where total earnings for the Acute Health program exceed the expenses incurred in delivery of the full quantity of services specified in the Health Services Agreement, the surplus may be used by the hospital for any purpose connected with its agreed function.

2.23 Privacy

2.23.1 The Hospital, its employees, agents or subcontractors must comply with the Department's Information Privacy Principles and any relevant legislative provisions that bind the Department in relation to privacy as amended from time to time including in relation to the collection, retention, management, use, quality, disclosure or transfer of information regardless of whether the Hospital, its employees, agents or subcontractors are bound by those legislative provisions.

2.23.2 The Hospital must ensure that its employees, agents and subcontractors comply with this requirement.

2.23.3 In this clause:

(a) "subcontractor" includes any person employed or engaged by a subcontractor; and

(b) "information" means:

(i) in relation to an employee - information acquired whilst acting in the course of employment;

(ii) in relation to an agent-information acquired whilst acting on behalf of the Hospital; or

(iii) in relation to a subcontractor-information acquired whilst providing services to, or on behalf of, the Hospital.

3. Fire Risk Management

3.1 Health and Safety.

The Agency is responsible for ensuring that it complies with all laws relating to fire protection, health, and general safety which apply to any premises from which the Agency operates irrespective of whether the relevant regulatory requirements place the obligation upon the owner or occupier of those premises.

The Agency is also responsible for ensuring that it complies with the DHS Capital Development Guidelines: Series 7 (Fire Risk Management) insofar as they are relevant to the Agency.

3.2 Operational Readiness.

The Agency must ensure that appropriate operational readiness measures are developed, implemented and reviewed. This includes (but is not limited to) fire emergency management and evacuation procedures, and training of staff to implement the procedures developed. The Agency must also ensure that essential services are maintained.

3.3 Client Placement.

At the time of patient placement in any premises, the Agency must ensure the premises complies with all laws relating to fire protection, health, and general safety which apply to any premises from which the Agency operates. The Agency must also ensure that the premises are suitable for the client to be evacuated reasonably, taking into account the fire systems installed, and the evacuation capacities of the client. Where any relevant change occurs which may affect the client's ongoing ability to evacuate safely, the suitability of the placement must be reassessed, and appropriate action taken.

3.4 Certificate of Fire Safety Compliance.

The Agency shall complete and return Certificate No. 6 of Fire Safety Compliance for 2000–2001 to the Department of Human Services by the due date set out in the "Agency Fire Safety Return Table for 2000–2001", which will be available on the DHS web site.

4. Revenue

Since the signing of the Australian Health Care Agreement (AHCA) the Commonwealth will compensate the States for reductions in the levels of private health insurance, but not for reductions in private patient revenue. Similarly, the Commonwealth may reduce funding to the State if the level of private health insurance increases above the trigger level of 32.2 percent. At the time of the signing of the AHCA in 1998–99 the level of privately insured persons in Victoria was 29 percent. Hospital revenue budgets are based on actual receipts 1998–99. Due to a 30 percent rebate on private health insurance commencing on 1 January 1999, and the introduction of Lifetime Health cover from 1 July 2000, the level of privately insured persons has been rising and at March 2000, 31.1 percent of Victorians were covered by private health insurance, now only some 1.1 percent below the trigger level. Nevertheless, no change has been made to hospital revenue budgets over 2000–01. These will remain based on 1998–99 actual collections.

Private patient revenue targets will not be adjusted downward during the year, unless a commensurate reduction in private patient throughput is also agreed with DHS. This will result in a reduction in WIES of which the initial allocation was to enable hospitals to achieve their private patient revenue target. Hospitals may not divert WIES allocated for the attainment of private patient revenue targets to other purposes.

Hospitals must continue to take vigorous actions to retain their levels of private patient revenue over 2000–2001. Any short falls will need to be made up by the hospital. Hospitals may retain any increases in private patient revenue in 2000-01.

4.1 Hospitals will raise fees and charges in accordance with the Department's manual *Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals*. It is located at:

http://www.dhs.vic.gov.au/ahs/feesman/index.htm

4.2 Admitted patient fees revenue includes fees raised for prostheses.

4.3 Any shortfall in outpatient revenue will be absorbed by the hospital. Any revenue generated in excess of the target will be retained by the hospital.

4.4 The States Fees Manual *Fees and Charges for Acute Health Services in Victoria: A Handbook for Public Hospitals* (as may be amended from time to time) stipulates that public hospitals are permitted to raise fees for the following non admitted patient services; but are not permitted to raise fees for the following services provided to admitted patients on discharge:

(a) dental services;

(b) spectacles and hearing aids;

(c) pharmaceutical at a level consistent with Pharmaceutical Benefits Scheme statutory copayments;

(d) surgical supplies;

(e) prostheses (this does not include artificial limbs or surgical implanted prostheses), aids and appliances and home modifications; and

(f) compensable and ineligible patients.

5. Goods and Services Tax

5.1 The Commonwealth Government's introduction of the Goods and Services Tax (GST) from 1 July 2000 requires that at a minimum, hospitals to be registered with the ATO, have an ABN, and are able to submit as required a Business Activity Statement to the ATO.

5.2 Hospital management is responsible for ensuring that their hospital is compliant and ready for the GST, and able to meet the reporting obligations from 1 July 2000. The Government will not be responsible for the inability of hospitals to identify and claim all input credits owing to them.

5.3 Services provided by hospitals to the Department of Human Services are liable to GST. Payment by the Department to hospitals for services will therefore include a GST element which hospitals will be required to remit to the ATO. Each fortnight, the Department will cash flow hospitals at a rate inclusive of GST. Hospitals therefore will not be disadvantaged in cash flow terms over the period between remitting GST paid by DHS, paying suppliers and claiming input credits from the ATO.

Public hospitals have been asked to provide the Department of Human Services with the ABN and written consent to allow the Department to raise a recipient created tax invoice (RCTI) rather than hospitals billing the Department for providing the service. This reduces the work for hospitals and necessitates the minimum of change. The receipt of this information is imperative so that the Department can claim the GST paid to hospitals as an input credit.

6. Cash Flow to Hospitals

6.1 Subject to meeting the requirements of the Hospital Conditions of Funding, notional fixed grant payments will be made available to the hospital in twenty four (24) payments based on negotiated cash flow requirements.

6.2 Cash flow to the hospital for variable payments will be based on the quarterly targets specified by hospitals and recorded in the Health Service Agreement.

6.3 Cash advanced for variable payments will be adjusted annually to match hospital earnings.

7. Force Majeure.

Circumstances (including industrial action), beyond the reasonable control of hospital management, may sometimes prevent the attainment of targetted throughput. The Department will continue its policy whereby, on a case by case basis it will fund hospitals according to their cash flow projections irrespective of throughput, but only for so long as force majeure continues. Hospitals are expected to actively mitigate their financial exposure and throughput decline during and following such events, and will not be additionally funded for extra “catch-up” throughput in specific service areas undertaken around a period of force majeure. The relevant quarter’s performance together with other available data and indicators will be used to determine the net impact of any period of force majeure.

8. Performance Accountability.

The operation and maintenance of a functional costing system is a requirement for good internal hospital management and essential for cost weight development. Funding is provided to Metropolitan Health Services and hospitals on the basis of achievement of best practice and efficient reporting of costs and services provided. Hospitals are required to account for costs and effectiveness of services at the patient level. A component of funding provided for throughput is therefore provided on the basis of responsiveness and precision of clinical costing and clinical management information systems.

In 2000–2001, penalties will be applied where adequate reporting of costs at a patient level are not available for system monitoring or cost weight development purposes. These penalties will be based on, but will exceed, the average cost of operating an appropriate clinical costing system according to the operating size of the agency.

9. Risk Management

The management of risk within hospitals is primarily the responsibility of hospital management who have the ability to identify and remove or ameliorate hazard. As a part of a risk management program the Department has taken out various insurance coverages. The cost of these coverages for the period 1999–2000 was $32 million. Insurance coverage is the final component of a risk management strategy and is not to be considered as an alternative to responsible management action.

The Department will develop in consultation with its insurers and hospitals, a position to complement the risk management program through the incorporation of a premium charge supported by excess imposition on the various policies held by the Department. The proposed implementation date is 1 January 2001. In respect of the excess hospitals will carry a portion of the financial risk from hazard management over which they have control.

A financial incentive for hospitals will be future reduction in premium costs arising from sustained improvement in risk management and claims performance.

10. Reporting

10.1 Definitions.

10.1.1 The hospital will comply with standard definitions for reporting financial and statistical data as set out in the Notes and Definitions for Use in Completing the 2000–01 Annual Return, the PRS/2 Manual Version 10.0, the Agency Information Management System Public Hospital User Manual Version 8.0, and any other amending documentation prepared by the Department.

10.1.2 The hospital will code patient episodes in accordance with the current Australian Coding Standards effective 1 July 2000, Victorian Additions to the Australian Coding Standards and ICD Coding Newsletters issued by the Department.

10.1.3 During 2000–01, hospitals will be advised of details of the operation of the Victorian Hospital Patient Register which will be developed for the linking of multiple admissions.

10.2 Supply of Statistics and Information.

10.2.1 The hospital will provide data to the Department as specified in the Health Service Agreement and in these Conditions of Funding.

The following categories of reporting are specified:

(a) Agency Level/Aggregated Hospital. The hospital will report on each of the Agency Level forms by the due dates.

(b) Program Specific. The hospital will report on the forms relevant to the hospital's program sources of funding. in accordance with the Agency Information Management System Public Hospital User Manual 2000–01.

The data specified in this section will be supplied in hard copy paper returns or computer readable form in accordance with Departmental specifications.

F1 financial returns are required 14 days after the end of the month for which the financial data is provided (e.g. the F1 for November is required by 14 December). Hospitals are encouraged to produce and forward this information earlier in line with the established trend for quicker management and financial feedback and reporting.

10.2.2 (a) Hospitals receiving funding under Commonwealth/State programs are required to submit regular statistical and financial reports for the monitoring of activity, payment of grants and acquittance to the Commonwealth.

(b) The information required, format and time lines for individual programs are detailed in the guidelines applicable to the appropriate Commonwealth or State Programs.

10.2.3 Metropolitan Health Services and major hospitals are required to operate and maintain, to a minimum standard, patient costing systems to allow recaliberation of the DRG funding formulae. Such hospitals are required to provide, to a designated independent party, sufficient accurate and timely information from the system, as specified by the Department to allow recalibration of the DRG relative weights. Penalties for non-provision of costing data will be based on but will exceed, the average cost of operating an appropriate clinical costing system according to the operating size of the agency.

10.2.4 In addition to the monthly reports specified in section 10.2.1, hospitals and aggregated hospitals are required to complete an Annual Return by 30 September 2001 in accordance with the detailed requirements specified by the Department.

10.2.5 Failure of a hospital to supply accurate and timely statistical and financial data in accordance with the Hospital Conditions of Funding may result in penalties or suspension of payments by the Department.

10.3 Transmission of Minimum Employment Data Set.

Hospitals are required to transmit information detailed in the Minimum Employment data set. Hospitals who have their payroll/budget processing undertaken by Allegiance systems will continue to have their data forwarded direct to the Department. Agencies opting to cease payroll/budget processing at Allegiance Systems are required to transmit the information detailed in the Minimum Employment Data Set directly to the Department. These agencies that provide the payroll/budget processing will be required to satisfactorily complete the Accreditation process information detailed in the Minimum Employment data.

10.4 Transmission of Admitted Patient Data.

10.4.1 The hospital will transmit data to the Victorian Admitted Episodes Dataset (VAED) via PRS/2 according to the timelines detailed in clauses 10.4.1.(a) and 10.4.1(b).

a) Admission and separation details for any month are to be transmitted in time for the VAED file consolidation on the **21st day** of the following month (see (d) below for processing schedule).

b) Diagnosis and procedure and sub-acute details in any month are to be transmitted in time for the VAED file consolidation on the **21st day** of the second month following (see (d) below for processing schedule).

c) Data for the financial year should be completed in time for the VAED file consolidation on **21 August**. Any corrections must be transmitted before finalisation of the VAED database on **21 September**.

d) It is the hospital's responsibility to ensure that data are transmitted to the VAED to meet the processing schedule for inclusion in the Allegiance Systems file consolidation on the **21st** of each month. Because of the various methods of transmission used by hospitals, and Allegiance Systems processing schedules, data must be

transmitted by the PRS/2 feeder systems to the VAED by, at the latest, the **17th day** of each month; however, weekends or public holidays may bring the effective deadline forward to the **14th day.**

e) WIES8 and sub-acute payments will be:

1. fully paid for data originally submitted in accordance with the deadlines specified in clauses 10.4.1.(a) and 10.4.1(b) above, even if data is subsequently amended; or

2. paid at a reduced rate (50 percent), or not recognised for payment, according to Schedules 2.1 and 2.2 located at the end of this section if the data has not been submitted in accordance with *either* deadline specified in clauses 10.4.1(a) and 10.4.1(b) above; or

3. not recognised for payment, if data has not been submitted in accordance with *both* deadlines specified in clauses 10.4.1(a) and 10.4.1(b) above.

This clause applies to all account classes including DVA.

f) If difficulties are anticipated in meeting the relevant data transmission timeframes for either admission and separation data, or diagnosis and procedure details, the hospital must write to the Department, indicating the nature of the difficulties, remedial action being taken, and the expected transmission schedule. Exemptions for one-off late submission of data will generally only be considered for computer system problems that are beyond the control of the hospital. (Hospitals undertaking the PRS/2 data submission testing process are automatically exempted). Exemptions for late submission of admission and separation data will also be considered for staffing problems that are beyond the control of the small rural hospitals. Exemptions for late submission of admission and separation data will be automatically granted to hospitals maintaining a consistently high level of timely data submission.

g) Data should be reconciled after each transmission against the hospital's in-house computer or manual systems and against the Monthly Return-Admitted Patients and any required corrections transmitted with data for the subsequent period.

10.5 Coding Audits.

10.5.1 The hospital will provide sufficient access to data and records to allow an audit of patient records, patient coding and data transmitted to the Victorian Admitted Episodes Dataset (VAED).

10.5.2 If the audit shows a difference in assignment of DRGs and/or other data items that alter the allocation of WIES, or that patients fail to meet admission criteria, then the number of weighted inlier equivalent separations and variable throughput payments to the hospital may be adjusted to take account of those differences.

10.5.3 Where the audit indicates that a hospital has been consistently erroneous in the application of admission criteria and/or coding standards, the Department will adjust or suspend the relevant throughput payments until such time as the issue is resolved to the satisfaction of the Department.

10.5.4 The Department also reserves the right to undertake supplementary audits to confirm an issue and/or monitor improvement; the cost of which is to be borne by the hospital.

10.5.5 Access to data and records for interstate patients transmitted to the Victorian Admitted Episodes Dataset (VAED) will also be required should State or Territory Health Authorities request an independent audit to verify information on DRG weighted separations.

10.5.6 The hospital will also provide sufficient access to data and records to allow an audit of patient records and data transmitted via the Agency Information Management System as part of the Victorian Ambulatory Classification System.

10.5.7 Access to data and records for emergency department patients and persons on waiting lists will also be required should this Department or the Commonwealth require an audit to verify information used for funding calculations either at the hospital or State level.

10.6 Access to Hospital Data.

The Department will have direct access to all data transmitted to the VAED, VEMD, ESIS and PRISM and to non-confidential aggregate data drawn from systems at Allegiance Systems including the transmission of cost data.

Schedule 2.1

Timelines for the Receipt of Admission and Separations Details (E2)

VAED Consolidation Date

Month of Separation 2000	21 September	21 October	21 November	21 December	21 January	21 February	21 March	21 April
July	Full Rate	Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
August	Full Rate	Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
September		Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
October			Full Rate	Half Rate	Nil	Nil	Nil	Nil
November				Full Rate	Half Rate	Nil	Nil	Nil
December					Full Rate	Half Rate	Nil	Nil
January						Full Rate	Half Rate	Nil

VAED Consolidation Date

Month of Separation 2001	21 March	21 April	21 May	21 June	21 July	21 August	21 September
January	Half Rate	Nil	Nil	Nil	Nil	Nil	Nil
February	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
March		Full Rate	Half Rate	Nil	Nil	Nil	Nil
April			Full Rate	Half Rate	Nil	Nil	Nil
May				Full Rate	Half Rate	Nil	Nil
June					Full Rate	Half Rate	Nil

Schedule 2.2

Timelines for the Receipt of Diagnoses and Procedure (X2, Y2) and Sub-Acute Details (S2)

VAED Consolidation Date

Month of Separation 1999	21 September	21 October	21 November	21 December	21 January	21 February	21 March	21 April
July	Full Rate	Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
August		Full Rate	Full Rate	Half Rate	Nil	Nil	Nil	Nil
September			Full Rate	Half Rate	Nil	Nil	Nil	Nil
October				Full Rate	Half Rate	Nil	Nil	Nil
November					Full Rate	Half Rate	Nil	Nil
December						Full Rate	Half Rate	Nil

VAED Consolidation Date

Month of Separation 2000	21 March	21 April	21 May	21 June	21 July	21 August	21 September
January	Full Rate	Half Rate	Nil	Nil	Nil	Nil	Nil
February		Full Rate	Half Rate	Nil	Nil	Nil	Nil
March			Full Rate	Half Rate	Nil	Nil	Nil
April				Full Rate	Half Rate	Nil	Nil
May					Full Rate	Half Rate	Nil
June						Full Rate	Half Rate